Supreme Court, U.S.
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No. 09-

IN THE

Supreme Court of the United States

DR. GARY MCKINNEY,

Petitioner,

v.

THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF COLORADO,

Respondent.

ON PETITION FOR A WRIT OF CERTIORARI TO THE
COLORADO COURT OF APPEALS

PETITION FOR A WRIT OF CERTIORARI

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QUESTIONS PRESENTED

In the State of Colorado, the Board of Medical Examiners acts for the State to govern licensure, discipline and professional review of licensees. The Board is divided into two panels consisting of six members each, of whom four are physicians from all specialties. The Inquiry Panel is responsible for investigating complaints and when appropriate referring the matter to the Office of the Attorney General for prosecution. An administrative law judge may preside over a hearing and enter an "initial decision with findings of fact, conclusions of law and a recommended sanction. If unprofessional conduct is proven the Hearings Panel determines the appropriate disciplinary sanction. There are no guidelines or standards for imposition of discipline. The BME imposed a sanction limiting Dr. McKinney to office practice of obstetrics and gynecology, essentially revoking his license, even though the factual findings were that there were "no pervasive problems" with Dr. McKinney's practice. In contrast, other doctors found to have committed substandard practices even resulting in death received only letters of admonition.

There are two questions presented:

1. Does Colorado's process for imposing and reviewing disciplinary action against licensed professionals, with no guidelines or consideration of sanctions imposed in other cases, by a panel of volunteers selected through political appointment, provide due process to a licensee?

2. In determining whether a sanction is arbitrary and capricious, should the reviewing court continue to operate in the same vacuum as the Board, or should it consider sanctions imposed in other cases, available through the Board's website, to provide the licensee with due process?

TABLE OF CONTENTS

	Page
QUESTIONS PRESENTED	i
TABLE OF CONTENTS	iii
TABLE OF APPENDICES	iv
TABLE OF CITED AUTHORITIES	v
OPINION BELOW	1
STATEMENT OF JURISDICTION	1
CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED	1
STATEMENT OF THE CASE	9
REASONS FOR GRANTING THE PETITION	15
I. Review is necessary to establish substantive due process requirements for imposing discipline on a licensed professional.	16
II. Review is necessary to establish procedural due process requirements of considering other decisions of the agency to ensure that sanctions are not arbitrary and capricious.	21
CONCLUSION	24

TABLE OF APPENDICES

Page

Appendix A — Order Of The Colorado Court Of Appeals Announced April 9, 2009 ..... 1a

Apendix B — Final Board Order Of The State Board Of Medical Examiners, State Of Colorado Dated May 21, 2008 ..... 7a

Appendix C — Initial Decision Of The State Of Colorado, Office Of Administrative Courts Dated January 18, 2008 ..... 10a

Appendix D — Order Of The Colorado Supreme Court Denying Petition For Writ Of Certiorari Dated September 14, 2009 ..... 60a

TABLE OF CITED AUTHORITIES

Page

Cases:

Avalanche Indus., Inc. v. Indus. Claim Appeals, Office, 166 P.3d 147 (Colo. App. 2007), *aff'd sub nom. Avalanche Indus., Inc. v. Clark*, 198 P.3d 589 (Colo. 2008) 16

Brammer-Hoelter v. Twin Peaks Charter Acad., 81 F. Supp.2d 1090 (D. Colo. 2000) 16

Colo. Real Estate Comm'n v. Hanegan, 947 P.2d 933 (Colo. 1997) 22

Co. St. Bd. of Medical Examiners v. McCroskey, 940 P.2d 1044 (Colo. App. 1996) 21

Hill v. Colorado, 530 U.S. 703, 120 S.Ct. 2480, 147 L.Ed.2d 597 (2000) 17

Kramer v. Colo. Dept. of Rev., 964 P.2d 629 (Colo. App. 1998) 19

Ohlson v. Weil, 953 P.2d 939 (Colo. App. 1997) ... 19

People v. Bovard, 87 P.3d 215 (Colo.App.2003), *rev'd on other grounds*, 99 P.3d 585 (Colo. 2004) . 16

People v. Stanley, 170 P.3d 782 (Colo. App. 2007) . 22

Quaker Court Limited Liability Co. v. BOCC, 109 P.3d 1027 (Colo. App. 2004) 21, 24

Cited Authorities

Page

Roseland Inn, Inc. v. McClain, 118 Mich. App. 724, 325 N.W.2d 551 (1982) 17, 18

Rosenthal v. Dep't of Revenue, 40 Colo. App. 422, 579 P.2d 1176 (1978), *rev'd on other grounds*, 197 Colo. 506, 594 P.2d 580 (1979) 18

Salazar v. Am. Sterilizer Co., 5 P.3d 357 (Colo. App. 2000) 17

Stockade, Inc. v. Local Licensing Authority, 40 Colo. App. 429, 576 P.2d 571 (1978) 18

United States v. Williams, 553 U.S. 285, 128 S.Ct. 1830, 170 L.Ed.2d 650 (2008) 17

United States Constitution:

U.S. Constitution Amendment 14, § 1 ..... 1, 15, 16

Statutes:

28 U.S.C. § 1257(a) 1

Administrative Procedure Act, § 24-4-106 6

Colorado Medical Practices Act, § 12-23-101 to 202

Colorado Medical Practices Act, § 12-36-118 ... 2

Cited Authorities

Page

State Administrative Procedure Act, § 24-4-101 to 108 19

Rule:

Colorado Appellate Rule 35(f) 1

Other Authorities:

Colo. Const. art. II, § 25 16

Department of Regulatory Agencies, http://www.dora.state.co.us/doraimages 13

OPINION BELOW

The Supreme Court of the State of Colorado entered its order denying the petition for certiorari on September 14, 2009. A copy of the order is in the Appendix at 60a. The Court of Appeals of the State of Colorado announced its decision on April 9, 2009. Pursuant to Colorado Appellate Rule 35(f), that decision was not selected for official publication. A copy of the decision is in the Appendix at 1a. The decision of the Hearings Panel and the administrative law judge are in the Appendix at 7a and 10a.

STATEMENT OF JURISDICTION

This Court's jurisdiction is invoked under 28 U.S.C. § 1257(a).

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

U.S. Constitution Amendment 14, § 1.

Citizenship defined – privileges of citizens.

All persons born or naturalized in the United States, and subject to the jurisdiction thereof, are citizens of the United States and of the state where they reside. No state shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any state deprive any person of life, liberty or property without due

process of law, nor deny to any person within its jurisdiction the equal protection of the laws.

Medical Practices Act,

§ 12-36-118. Disciplinary action by board – immunity

* * *

(e) All formal complaints shall be heard and determined in accordance with paragraph (f) of this subsection (5) and *section 24-4-105, C.R.S.* Except as provided in subsection (1) of this section, all formal hearings shall be conducted by the hearings panel. The licensee may be present in person and by counsel, if so desired, to offer evidence and be heard in his or her own defense. At formal hearings, the witnesses shall be sworn and a complete record shall be made of all proceedings and testimony.

(f) Except as provided in subsection (1) of this section, an administrative law judge shall preside at the hearing, and he shall advise the hearings panel on all such legal matters in connection with the hearing as the panel may request. He shall provide such advice or assistance as the hearings panel may request in connection with its preparations of its findings and recommendations or conclusions to be made. Such administrative law judge

shall have the authority to administer oaths and affirmations, sign and issue subpoenas, and perform such other duties as the hearings panel may authorize him to perform. Such administrative law judge shall have the qualifications provided in *section 24-30-1003(2), C.R.S.*, with five years' experience as a licensed attorney.

(g)(I) To warrant a finding of unprofessional conduct, the charges shall be established as specified in *section 24-4-105(7), C.R.S.* Except as provided in subsection (1) of this section, the hearings panel shall make a report of its findings and conclusions which, when approved and signed by a majority of those members of the hearings panel who have conducted the hearing pursuant to paragraphs (e) and (f) of this subsection (5), shall be and become the action of the board.

(II) If it is found that the charges are unproven, the hearings panel, or an administrative law judge sitting in lieu of the hearings panel pursuant to subsection (1) of this section, shall enter an order dismissing the complaint.

(III) If the hearings panel finds the charges proven and orders that discipline be imposed, it shall also determine the extent of such discipline, which shall be in the form of a letter of admonition, suspension for a definite or indefinite period, or revocation of license to

practice. In lieu of a suspension, the hearings panel may impose a fine not to exceed ten thousand dollars. In determining appropriate disciplinary action, the hearings panel shall first consider sanctions that are necessary to protect the public. Only after the panel has considered such sanctions may it consider and order requirements designed to rehabilitate the licensee or applicant. If discipline other than revocation of a license to practice is imposed, the hearings panel may also order that the licensee be granted probation and allowed to continue to practice during the period of such probation. The hearings panel may also include in any disciplinary order that allows the licensee to continue to practice such conditions as the panel may deem appropriate to assure that the licensee is physically, mentally, morally, and otherwise qualified to practice medicine or practice as a physician assistant in accordance with generally accepted professional standards of practice, including any or all of the following:

(A) Submission by the respondent to such examinations as the hearings panel may order to determine his physical or mental condition or his professional qualifications;

(B) The taking by him of such therapy or courses of training or education as may be needed to correct deficiencies found either in the hearing or by such examinations;

(C) The review or supervision of his practice as may be necessary to determine the quality of his practice and to correct deficiencies therein; and

(D) The imposition of restrictions upon the nature of his practice to assure that he does not practice beyond the limits of his capabilities.

(III.5) Any moneys collected pursuant to subparagraph (III) of this paragraph (g) shall be transmitted to the state treasurer, who shall credit the same to the general fund.

(IV) Upon the failure of the licensee to comply with any conditions imposed by the hearings panel pursuant to subparagraph (III) of this paragraph (g), unless due to conditions beyond the licensee's control, the hearings panel may order suspension of the licensee's license to practice medicine or practice as a physician assistant in this state until such time as the licensee complies with such conditions.

(V) In making any of the orders provided in subparagraphs (III) and (IV) of this paragraph (g), the hearings panel may take into consideration the licensee's prior disciplinary record. If the hearings panel does take into consideration any prior discipline of the licensee, its findings and recommendations shall so indicate.

(VI) In all cases of revocation, suspension, or probation, the board shall enter in its records the facts of such revocation, suspension, or probation and of any subsequent action of the board with respect thereto.

(VII) to (IX) Deleted by Laws 1979, S.B.296, § 14.

(h) The attorney general shall prosecute those charges which have been referred to him by the inquiry panel pursuant to subparagraph (IV) of paragraph (c) of subsection (4) of this section. The board may direct the attorney general to perfect an appeal.

* * *

Administrative Procedure Act,

§ 24-4-106. Judicial review

* * *

(7) If the court finds no error, it shall affirm the agency action. If it finds that the agency action is arbitrary or capricious, a denial of statutory right, contrary to constitutional right, power, privilege, or immunity, in excess of statutory jurisdiction, authority, purposes, or limitations, not in accord with the procedures or procedural limitations of this article or as otherwise required by law, an

abuse or clearly unwarranted exercise of discretion, based upon findings of fact that are clearly erroneous on the whole record, unsupported by substantial evidence when the record is considered as a whole, or otherwise contrary to law, then the court shall hold unlawful and set aside the agency action and shall restrain the enforcement of the order or rule under review, compel any agency action to be taken which has been unlawfully withheld or unduly delayed, remand the case for further proceedings, and afford such other relief as may be appropriate. In making the foregoing determinations, the court shall review the whole record or such portions thereof as may be cited by any party. In all cases under review, the court shall determine all questions of law and interpret the statutory and constitutional provisions involved and shall apply such interpretation to the facts duly found or established.

* * *

(11)(a) Whenever judicial review of any agency action is directed to the court of appeals, the provisions of this subsection (11) shall be applicable except for review of orders of the industrial claim appeals office.

(b) Such proceeding shall be commenced by the filing of a notice of appeal with the court of appeals within forty-five days after the date of the service of the final order entered in the

action by the agency, together with a certificate of service showing service of a copy of said notice of appeal on the agency and on all other persons who have appeared as parties to the action before the agency. The date of service of an order is the date on which a copy of the order is delivered in person or, if service is by mail, the date of mailing.

(c) The record on appeal shall conform to the provisions of subsection (6) of this section. The designation and preparation of the record and its transmission to the court of appeals shall be in accordance with the Colorado appellate rules. A request for an extension of time to transmit the record shall be made to the court of appeals and may be granted only by that court.

(d) The docketing of the appeal and all procedures thereafter shall be as set forth in the Colorado appellate rules. The agency shall not be required to pay a docket fee. All persons who have appeared as parties to the action before the agency who are not designated as appellants shall, together with the agency, be designated as appellees.

(e) The standard for review as set forth in subsection (7) of this section shall apply to appeals brought under this subsection (11).

STATEMENT OF THE CASE

Petitioner Dr. McKinney was licensed by the State of Colorado in 1988. In 2007, the Board of Medical Examiners (BME) filed a formal complaint against Dr. McKinney, asserting that substandard care had been provided to two patients in 2004 and 2005. When the formal complaint was originally filed, the BME did not seek any probation, limitation or restrictions on Dr. McKinney's license or his ability to practice obstetrics or gynecology. It was not until it rendered its final decision on May 21, 2008, well over a year after the formal complaint was filed, that the BME restricted Dr. McKinney's practice.

The 2007 formal complaint alleged violation of § 12-36-117(p) and (cc), C.R.S., consisting of substandard care and failure to make essential entries on charts. At the beginning of the hearing before the Administrative Law Judge (ALJ), the Panel dismissed twelve paragraphs of the complaint as to Patient A and dismissed additional significant allegations as to Patient B. Following the presentation of evidence, the ALJ sustained one count of substandard care to Patient A – intentionally cutting the bowel during surgery, but which Dr. McKinney agreed would be substandard practice, which he vehemently denied he had done intentionally – he testified that the bowel tore during blunt dissection to remove a fibroid and he called a general surgeon to repair the bowel. The ALJ also sustained two counts as to Patient B – failure to routinely prescribe a narcotic pain medication following surgery notwithstanding conflicting evidence of the standard of care for prescribing such medications, and failure to provide

on-call coverage for 1 and ½ hours after surgery. The ALJ did not sustain any other allegations, and specifically concluded that these incidents did not demonstrate a pervasive problem with Dr. McKinney's practice. *See* Initial decision at p. 22.

The ALJ carefully weighed whether probation and practice monitoring could work for Dr. McKinney, given that he is one of only two Ob/Gyns in Canon City. The ALJ concluded that, although the restriction might be onerous on Dr. McKinney, it was workable. The ALJ found insufficient evidence that the findings as to these two patients established a pervasive problem with Dr. McKinney's practice that might warrant revocation of his license. The ALJ also specifically found that public safety concerns could be adequately addressed by probation, a thorough assessment of Dr. McKinney's abilities and knowledge, educational requirements, and practice monitoring.

However, despite dismissal of twelve paragraphs as to Patient A and more as to Patient B, the ALJ's findings and carefully weighed recommendations, Inquiry Panel B (the Panel) filed exceptions to this Initial Decision. Devoid of any rationale or supporting authority, the Panel argued without any further findings of fact, that public safety required revocation of Dr. McKinney's license. Although the Panel purportedly accepted the ALJ's factual findings, it nonetheless strenuously argued that Dr. McKinney's license should be revoked to protect public safety. First, it asserted that, as to Patient A, Dr. McKinney's cutting of the bowel led to long-term possibly permanent injury to Patient A. In so arguing, the Panel did not present any evidence or

argument as to how Patient A's possible long-term problem was caused by an unintentional tear as contrasted with an intentional cut. There was absolutely no evidence at the hearing that Patient A sustained long term, possibly permanent, injury. Review of the ALJ's findings of fact indicates that Patient A had problems with the repair to the bowel because there was leaking around the repair site. There is no indication that the leaking around the repair site, when Dr. McKinney did not perform the repair, was a result of Dr. McKinney's action.

The Panel then argued about the care of Patient B, erroneously asserting that *all* experts testified that the standard of care was to provide oral narcotic pain medicine post-surgery for her procedure. But the ALJ in ¶ 64 noted that Dr. McKinney's expert did not say that.

The Panel then argued that because Dr. McKinney does not routinely prescribe oral narcotic pain medication the general public is at risk. The Panel overlooked Dr. McKinney's testimony that he does not automatically prescribe oral narcotics because it is important to monitor individual reaction to pain and to avoid masking problems with narcotics.

Finally the Panel argued that there were four aggravating factors that required revocation. Here, the Panel relied upon allegations which the ALJ had not sustained, and improperly went outside the record. For example, it claimed that because there was only one other Ob/Gyn in Canon City there was no way Dr. McKinney's practice could be monitored because he

had no one to consult in his practice. This argument is directly contrary to the ALJ's finding. The Panel also stated that revocation was appropriate because Dr. McKinney showed no remorse or admission of a need to alter his practice. As the ALJ noted, this could be a litigation strategy and in no way established Dr. McKinney's liability, attitude or that he was unwilling to accept probation and monitoring.

As the ALJ concluded, the allegations that were sustained did not rise to the level warranting revocation of Dr. McKinney's license.

Notwithstanding the ALJ's findings of fact and conclusions of law, the Hearing Panel, based on erroneous consideration of matters not sustained by the ALJ or outside the record, rejected the ALJ's recommended sanction. The Panel's short order states that Dr. McKinney had a pattern of discipline demonstrating a lack of professional judgment and discrepancies involving medical records and his statements – this "pattern of discipline" was based solely on a single letter of admonition (LOA) from a 2000 case. It is important to note that a letter of admonition is not an adjudication of the conduct asserted in the LOA. The Panel imposed a sanction of barring Dr. McKinney from hospital and surgical practice, which in essence revoked his license.

Dr. McKinney appealed to the Court of Appeals, arguing that the discipline imposed was arbitrary and capricious, because it was far more severe than sanctions imposed on other doctors for comparable or more serious practices. In support of this argument,

Dr. McKinney cited several specific BME decisions, and submitted a chart summarizing some 250 BME decisions reviewed at the Department of Regulatory Agencies, http://www.dora.state.co.us/doraimages. The chart identified the specific decisions, identified the findings regarding substandard practices, and the discipline imposed.

In summary, seventy-six letters of admonition (LOAs) were issued, thirteen licenses were suspended, seventeen were placed on probation, four licenses were surrendered, three licenses were revoked, one license was inactivated, and only seven were permanently restricted. (There were not final actions in all cases reviewed, and in some cases both a LOA and a probation period were imposed.) In fact in one matter (#3000), involving a Dr. Bascom, a twenty-seven year old patient sustained an injury to the common bile duct during laparoscopic surgery, which required additional surgeries and hospitalization, similarly to the findings of fact as to Patient A for Dr. McKinney, and the BME issued a Letter of Admonition to Dr. Bascom.

The results of this review of BME disciplinary actions show the complete disparity of sanctions imposed by the BME among physicians, despite similar offenses. In the cases reviewed, the BME issued an astonishing number of LOAs regardless of the underlying complaint. A LOA could be issued for a multitude of offenses, without any rationale or transparency as to why a LOA was chosen over more severe sanctions. For instance, in some cases a LOA was issued for merely failing to respond to correspondence from the BME, for a physician having alcohol or drug dependency, for

engaging in sexual relationships with patients, or for multiple counts of substandard care resulting in patients requiring multiple additional surgeries, suffering permanent impairment, or even death. *See* Disciplinary Matter involving Dr. Karel Prochazka (#2997) (Letter of Admonition was issued when a patient died during surgery); Disciplinary Matter involving Dr. Ann Arrigo (#2127) (Letter of Admonition was issued after delivery and baby suffered significant hypoxic encephalopathy and patient died); and Disciplinary Matter involving Dr. Traci Sims (#2998) (Letter of Admonition was issued after baby was delivered with forceps and presented with Apgars of 0, 4 and 4); *see also* Disciplinary Matter involving Dr. Charles Gartner (#2954) (Ob/Gyn was given probation and surgical restrictions, during the probationary period, despite findings of facts as to eight gynecology cases and four obstetric cases); and Disciplinary Matter involving Dr. Franklin Chow (#2946) (physician was given probation, with no surgical restrictions, despite findings of facts that physician gave substandard case to a patient during a laparoscopic hysterectomy where he cut one or more blood vessels while placing a trocar, causing the patient to bleed to death).

The Court of Appeals declined to consider Dr. McKinney's argument, that a review of the hundreds of BME decisions showed that there was disparate treatment of similar matters, *i.e.*, an abuse of discretion, and that the BME's failure to follow any established guidelines for disciplinary action or reprimands resulted in arbitrary and capricious sanctions, characterizing the review of BME's decisions as evidence outside the record. (Slip opinion p. 6-7). The Court of Appeals stated

that Dr. McKinney had failed to present the review of the BME's decisions to the Board, and that he was asking the Court to "second guess" the Board based on an argument and evidence never presented to the Board. *Id.* "That would not be consistent with our role as an appellate court applying a deferential standard of review." *Id.* Thus, without any review of the BME decisions, the Court of Appeals affirmed the discipline imposed on Dr. McKinney.

REASONS FOR GRANTING THE PETITION

Whether an administrative agency can constitutionally impose sanctions in a disciplinary proceeding on a licensee without promulgating any guidelines or standards for the sanction imposed is an important question implicating substantive due process under the Fourteenth Amendment of the United States Constitution. Many professions – such as medical, legal, plumbing, appraising real property – require a license from an administrative agency. The licensing agency, to fulfill its role in reviewing complaints against licensees, needs to have not only standards of conduct to determine whether discipline is appropriate, but also to determine what discipline is appropriate rather than arbitrary and capricious.

A court reviewing the imposition of discipline should consider the sanctions imposed in other cases as part of its determination that the sanction is not arbitrary and capricious. Particularly in light of precedent allowing consideration of public records of an agency, a reviewing court should reach the merits of an argument based on

those public records which clearly established the lack of a relationship between substandard practice and the sanction imposed.

Review by this court could set procedural and substantive due process standards for disciplinary actions and sanctions imposed against licensed professionals, in all states of the Union.

I. Review is necessary to establish substantive due process requirements for imposing discipline on a licensed professional.

Both the United States and Colorado Constitutions prohibit the state from depriving a person of life, liberty, or property without due process of law. U.S. Const., Amend. 14, § 1(a); Colo. Const. art. II, § 25. *See People v. Bovard*, 87 P.3d 215, 216 (Colo.App.2003), *rev'd on other grounds*, 99 P.3d 585 (Colo. 2004). Procedural due process, on the one hand, requires fundamental fairness in procedure and is met if the party is provided with notice and an opportunity to be heard. *Avalanche Indus., Inc. v. Indus. Claim Appeals, Office*, 166 P.3d 147, 150 (Colo. App. 2007), *aff'd sub nom. Avalanche Indus., Inc. v. Clark*, 198 P.3d 589 (Colo. 2008). Substantive due process, on the other hand, guarantees that the state will not deprive a person of those rights for arbitrary reasons regardless of how fair the procedure is. *Brammer-Hoelter v. Twin Peaks Charter Acad.*, 81 F. Supp.2d 1090, 1100 (D. Colo. 2000).

Due process is violated where a provision "fails to provide a person of ordinary intelligence fair notice of what is prohibited, or is so standardless that it

authorizes or encourages seriously discriminatory enforcement." *United States v. Williams*, 553 U.S. 285, 128 S.Ct. 1830, 1845, 170 L.Ed.2d 650 (2008) (citing *Hill v. Colorado*, 530 U.S. 703, 732, 120 S.Ct. 2480, 147 L.Ed.2d 597 (2000).

Substantive due process requires the regulation or government action be reasonable, as distinguished from arbitrary or capricious. *Salazar v. Am. Sterilizer Co.*, 5 P.3d 357 (Colo. App. 2000).

The lack of standards for imposing disciplinary sanctions is the essence of a denial of due process. Other courts in a variety of licensing procedures have concluded that a lack of standards is a denial of due process.

The plaintiff in *Roseland Inn, Inc. v. McClain*, 118 Mich. App. 724, 325 N.W.2d 551 (1982), had applied to renew the liquor license for its tavern. After several inspections of the premises by town officials, plaintiff received a notice that a hearing was to take place to determine whether the request for renewal should be denied. At the hearing, town officials and residents spoke, and the Township Board made findings on alleged violations of fire safety, electrical, plumbing, and public health regulations and other complaints. Plaintiff then filed suit to enjoin defendants from refusing to renew the license.

The court in *Roseland* observed that review of whether the actions taken at the hearing were arbitrary and capricious was hampered by the absence of any standards against which to measure the decision. Its

concern extended to the lack of guidelines or standards which formed the basis for the township's *initial* request for revocation or nonrenewal:

> Plaintiff argues persuasively that a liquor licensee has the right to know what criteria must be met in order to fulfill the requirements for maintaining or renewing a liquor license and that the lack of standards to give notice of such criteria violates a licensee's right to due process of law.
>
> . . . .
>
> We simply hold that due process requires a local legislative body to establish some standards or guidelines which provide liquor licensees with notice of what criteria will result in *initiation* of license nonrenewal or revocation proceedings.

Id. at 554-555.

> *See also Rosenthal v. Dep't of Revenue*, 40 Colo. App. 422, 579 P.2d 1176 (1978) (because no guidelines had been established to grant or deny an application to enlarge premises under hotel and restaurant license, neither the public nor the courts had any means of knowing in advance what evidence might be considered material), *rev'd on other grounds*, 197 Colo. 506, 594 P.2d 580 (1979); *Stockade, Inc. v. Local Licensing Authority*, 40 Colo. App. 429, 576 P.2d 571 (1978).

The Colorado Medical Practices Act, § 12-23-101 to 202, and State Administrative Procedure Act, § 24-4-101 to 108, address the licensing and disciplinary actions against doctors. Section 24-4-106(7) provides that the court shall set aside the agency order if it is, among other things, arbitrary or capricious. See *Kramer v. Colo. Dept. of Rev.*, 964 P.2d 629 (Colo. App. 1998); *Ohlson v. Weil*, 953 P.2d 939 (Colo. App. 1997).

The Board of Medical Examiners has not promulgated any standards or guidelines for determining what sanction may be appropriate. Because the Board is comprised of volunteer appointees, it has little if any sense of what sanctions have been imposed historically. This case demonstrates that a sanction may be surprisingly lenient in one case, and in a similar case, draconian.

In this case, Dr. McKinney, the only African American doctor in Canon City, submitted his argument to the Court of Appeals that: (1) the sanction imposed on him was not a result of the application of any established BME sanction guidelines; (2) there is disparate treatment by the BME of physicians; and (3) the sanction imposed on him by the BME was not comparable to the sanctions imposed on other doctors. He supported these arguments with a review and discussion of other BME decisions.

The results of this review of disciplinary actions show the complete disparity of sanctions imposed by the BME among physicians, despite similar offenses. In the cases reviewed, the BME issued an astonishing number of letters of admonition (LOAs) regardless of the

underlying complaint. A LOA could be issued for a multitude of offenses, without any rationale or transparency as to why a LOA was chosen over more severe sanctions.

Surgical restrictions were rarely imposed, and then only in conjunction with probation and practice monitoring. The cases that resulted in probation with surgical restrictions were based on numerous counts of substandard care. See, e.g. Charles Gartner, M.D., license No. 16580 (eight gynecological complaints and four obstetrics complaints); Franklin Chow, M.D. license no. 25189 (patient died during laparoscopic hysterectomy; restriction on laparoscopic procedures during probation). In contrast, see David Thayer, M.D., license no. 27055 (patient died, after preoperative and interoperative substandard case; sanction of probation with no surgical restrictions).

Dr. Cohen on January 11, 2007 regarding Case Nos. 2004-002695-A and 2006-001863-A. In the BME final decision to Dr. Cohen, he received disciplinary action in the form of a LOA. Like Dr. McKinney, Dr. Cohen was charged with substandard care as to two patients. As to Patient A, Dr. Cohen administered a vacuum delivery after six unsuccessful attempts by another physician and a request for Caesarean section. The Caesarean delivery was unsuccessful and the infant later died at Children's Hospital. As to Patient B, Dr. Cohen performed an elective bilateral tubal litigation and took a specimen which was a ligament and not a fallopian tube. See also BME Case No. 2006-001944A November 15, 2006 LOA to Dr. Ransy Jeffrey: substandard practice to perform hysterectomy without first ruling out pregnancy; patient was 12 weeks pregnant).

See also *Co. St. Bd. of Medical Examiners v. McCroskey*, 940 P.2d 1044 (Colo. App. 1996) (letter of admonition for record keeping violations).

The sanction imposed on Dr. McKinney permanently restricts his non-office practice – barring any surgery and bars delivery of babies, essentially revoking his license to practice medicine as an Ob/Gyn. Yet, in the case of Dr. James Bascom, license no. 3000, who damaged the bile during a surgery so that the patient required multiple follow-up surgeries, only a LOA was issued. This is nearly identical to Dr. McKinney's patient A.

Regardless of the severity of offenses or similarity of allegations, there is no pattern or predictability in sanctions imposed by the BME. This is the very essence of arbitrariness and denial of substantive due process. Cf. *Quaker Court Limited Liability Co. v. BOCC*, 109 P.3d 1027, 1032-1033 (Colo. App. 2004) (standards necessary to ensure state action is not arbitrary, but consistent and rational).

II. Review is necessary to establish procedural due process requirements of considering other decisions of the agency to ensure that sanctions are not arbitrary and capricious.

The Court of Appeals of the State of Colorado held that Dr. McKinney's analysis and presentation of other BME decisions was "evidence" outside the record produced for the first time on appeal. As a matter of procedural due process, the Court should have considered these other decisions of the agency as part

of the determination whether the sanction imposed was arbitrary and capricious. Cf. *Colo. Real Estate Comm'n v. Hanegan*, 947 P.2d 933 (Colo. 1997) (imposing the same sanction on broker as imposed on others with identical violation).

The Court's refusal to consider other decisions of the agency denied Dr. McKinney any method of establishing that the sanction imposed on him was arbitrary and capricious. The BME had no standards or guidelines for imposing sanctions so Dr. McKinney could not argue whether the sanction deviated from a guideline or standard. Comparison to other cases was his best hope of establishing that the sanction imposed on him was arbitrary and capricious. Yet until a sanction was imposed he did not know that he would be in the position of arguing that the sanction was arbitrary. Thus, he had no basis for discussing sanctions in other cases until he himself had been sanctioned.

A court may take judicial notice of the public records of an agency. *People v. Stanley*, 170 P.3d 782, 794 (Colo. App. 2007). The BME decisions cited by Dr. McKinney to the Court of Appeals are public records, obtained from the public website. The Court of Appeals erred in characterizing these decisions as "evidence" that was not in the record. Rather, these decisions are authorities of the BME. The decisions were cited as authority for actions taken by the BME. Just as in *Hanegan, supra*, reference was made to sanctions imposed in other cases, and the Court of Appeals considered those other cases. Here Dr. McKinney, like the petitioner in *Hanegan*, sought to show that the discipline in his case was arbitrary and capricious because of the variance in

sanctions imposed by the BME. Therefore, the chart summarizing those decisions is not evidence, but rather it is argument. It should have been considered and failure to consider the argument was denial of procedural due process.

The Court of Appeals' decision requires a licensee to pre-emptively argue to the BME that the discipline not yet imposed would be arbitrary and capricious unless consistent with other BME cases, and submit as "evidence" BME decisions to demonstrate what would be an appropriate discipline. This is contrary to logic and reason.

A challenge to discipline imposed by the BME of necessity occurs only after the discipline has been imposed. Because the standard of review is for an abuse of discretion in rendering a decision, the licensee must show a reason why the discipline imposed was arbitrary and capricious. If the licensee may not compare his case to other disciplinary actions of the BME, and there are no published standards for imposing discipline, there is no way that the licensee can obtain effective review.

Dr. McKinney cited other BME cases, well over two hundred, and contrasted them with the discipline imposed in his case. Dr. McKinney argued strenuously that there is no discernible pattern in the BME disciplinary cases, which is the very essence of arbitrariness.

To allow the Court of Appeals to rule that somehow this argument and the cited BME decisions should have been introduced at the BME hearing, before any

sanction had been imposed, elevates the difficult task of establishing an abuse of discretion to the impossible. It denies Dr. McKinney and other similarly situated physicians due process afforded to them under the Constitution of the United States. Cf. *Quaker Court Limited Liability Co. v. BOCC,* 109 P.3d 1027, 1032-1033 (Colo. App. 2004) (standards necessary to ensure state action is not arbitrary, but consistent and rational).

CONCLUSION

For all the foregoing reasons, Petitioner respectfully requests that the Supreme Court grant review of this matter.

Respectfully submitted,

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APPENDIX

APPENDIX A — ORDER OF THE COLORADO COURT OF APPEALS ANNOUNCED APRIL 9, 2009

COLORADO COURT OF APPEALS

Court of Appeals No.: 08CA1254
Colorado State Board of Medical Examiners
ME 2007-0003

Dr. Gary McKinney,

Respondent-Appellant,

v.

Board of Medical Examiners,

Appellee.

ORDER AFFIRMED

Division VII
Opinion by: JUDGE J. JONES
Russel and Gabriel, JJ., concur

NOT PUBLISHED PURSUANT TO C.A.R. 35(f)

Announced: April 9, 2009

Petitioner, Dr. Gary McKinney, appeals the Colorado Board of Medical Examiners' order restricting his license to practice medicine. We affirm.

Appendix A

I. Background

Dr. McKinney was licensed to practice medicine in the State of Colorado in 1988. He practices in the areas of obstetrics and gynecology.

In 2007, an Inquiry Panel filed a complaint against Dr. McKinney, alleging substandard practice in connection with his care and treatment of two patients. An administrative law judge (ALJ) found that Dr. McKinney had provided substandard care to both patients. Specifically, the ALJ found: (1) as to one patient, Dr. McKinney had deliberately severed and removed a portion of the patient's bowel during hysterectomy surgery, in violation of accepted standards of medical practice; and (2) as to the other patient, Dr. McKinney had failed to prescribe adequate post-surgery pain medication and had failed to insure on-call coverage for the patient following surgery. The ALJ further found that Dr. McKinney had failed to take remedial measures or to acknowledge his errors with respect to the two patients at issue.

The ALJ imposed a sanction of five years probation. In determining the appropriate sanction, the ALJ also considered the fact that Dr. McKinney had received a letter of admonition in 2003 for providing substandard care to a patient.

The Inquiry Panel filed exceptions to the ALJ's initial decision, contending that the sanction imposed by the ALJ was insufficient. The Inquiry Panel

requested that Dr. McKinney's license to practice medicine be revoked.

A separate Hearings Panel of the Board reviewed the ALJ's decision. It adopted the ALJ's findings of fact and conclusions of law, but determined that the sanction of probation was not adequate to protect the public. The Hearings Panel instead concluded that the appropriate sanction was to restrict Dr. McKinney's license to the office practice of obstetrics and gynecology, and permanently barred him from surgical practice in a hospital or ambulatory surgical center. The Hearings Panel based its decision on the nature of the violations in this case, the prior discipline, Dr. McKinney's demonstrated "lack of professional judgment," and discrepancies between the medical records and Dr. McKinney's statements in this case.

Dr. McKinney appeals.

II. Discussion

Dr. McKinney contends that the Hearings Panel's sanction restricting his license is arbitrary and capricious because it is more severe than sanctions imposed on other doctors for comparable or more serious violations. We conclude that the Board's choice of sanction was not arbitrary and capricious.

The Board, acting through a hearings panel, is not bound by an ALJ's initial decision concerning the appropriate sanction. Rather, it has the authority to

modify that sanction or to set it aside and impose a different sanction in conformity with the facts and the law. *See Colo. State Bd. of Med. Exam'rs v. Ogin*, 56 P.3d 1233, 1240 (Colo. App. 2002), *Colo. State Ed. of Med. Exam'rs v. Hoffner*, 832 P.2d 1062, 1067 (Colo. App. 1992). In determining what sanction to impose, the Board must first consider disciplinary actions that are necessary to protect the public. § 12-36-118(5)(g)(III), C.R.S. 2008.

As an administrative agency, the Board is afforded broad discretion in determining the appropriate sanction for unprofessional conduct. *Hoffner*, 832 P.2d at 1069; *Colo. State Bd. of Med. Exam'rs v. Reuter*, 786 P.2d 499, 500 (Colo. App. 1989). We may not substitute our judgment for that of the Board as to what constitutes an appropriate sanction. *See Ogin*, 56 P.3d at 1240; *Hoffner*, 832 P.2d at 1069. Rather, we may overturn the Board's decision only if we find that it acted in an arbitrary and capricious manner, made a determination that is unsupported by the record, erroneously interpreted the law, or exceeded its constitutional or statutory authority. § 24-4-106(7), C.R.S. 2008; *see Bourgeron v. City & County of Denver*, 159 P.3d 701, 706 (Colo. App. 2006); *see also Ogin*, 56 P.3d at 1240 (Board's "determination must be upheld on review unless it bears no relation to the conduct, is a gross abuse of discretion, or is manifestly excessive in relation to the needs of the public"). As relevant here, in determining whether the Board's decision was arbitrary and capricious, we must assess whether a reasonable person, considering all the evidence in the record, would be compelled to reach a different

conclusion. *Colorado State Bd. of Medical Exam'rs v. Johnson*, 68 P.3d 500, 502 (Colo. App. 2002).

In support of his contention on appeal, Dr. McKinney relies primarily on various Board disciplinary cases where, he submits, less harsh sanctions were imposed for comparable or more severe violations.

However, in reviewing an agency's decision, we are limited to considering the evidence in the record. *See Johnson*, 68 P.3d at 502, *Ramseyer v. Colo. Dept of Soc. Serv.*, 895 P. 2d 1188, 1192 (Colo. App. 1995). Dr. McKinney's counsel's characterizations of other cases, contained in Appendix A of the "Opening Brief," is not properly part of the record. There is no indication in the record that Dr. McKinney submitted this information to either the ALJ or the Hearings Board.

Though we could perhaps take judicial notice of the five agency decisions attached to Dr. McKinney's Opening Brief (pertaining to Drs. Gartner, Chow, Thayer, Cohen, and Jeffrey), *see People v. Stanley*, 170 P.3d 782, 794 (Colo. App. 2007) (court may take judicial notice of public records of an administrative agency), we may not take judicial notice of counsel's characterizations of the decisions in hundreds of other cases. In any event, we decline to consider any of these materials. Dr. McKinney essentially asks us to second guess the Board's decision based on an argument and evidence he never presented to the Board. That would not be consistent with our role as an appellate court applying a deferential standard of review. *See Lobatz v. U.S. West Cellular of California*,

Inc., 222 F.3d 1142, 1148 n.4 (9th Cir. 2000); *Kemlon Products & Dev. Co. v. United States*, 646 F.2d 223, 224 (5th Cir. 1981); *Melong v. Micronesian Claims Comm'n*, 643 F.2d 10, 12 n.5 (D.C. Cir. 1980); *Turtle Mountain Band of Chippewa Indians v. United* States, 490 F.2d 935, 945 (Ct. Cl. 1974); *Vons Companies, Inc. v. Seabest Foods, Inc.*, 926 P.2d 1085, 1091 n.3 (Cal. 1996).

Moreover, we are not persuaded that the information provided by Dr. McKinney, even if taken at face value, establishes the disparate treatment he alleges. There are differences between those cases (as well as the two decisions of divisions of this court on which Dr. McKinney relies) and this one, such as the severity and number of the violations.

The Board must determine appropriate discipline on a case-by-case basis. *See Hoffner*, 832 P.2d at 1069. Here, it is clear the Board considered appropriate factors and carefully tailored the sanction to serve its primary obligation of protecting the public. On this record, we cannot conclude that the Board abused its broad discretion to fashion an appropriate sanction.

The order is affirmed.

JUDGE RUSSEL and JUDGE GABRIEL concur.

APPENDIX B — FINAL BOARD ORDER OF THE STATE BOARD OF MEDICAL EXAMINERS, STATE OF COLORADO DATED MAY 21, 2008

BEFORE THE STATE BOARD OF MEDICAL EXAMINERS STATE OF COLORADO

Case No. ME 2007-0003

FINAL BOARD ORDER

IN THE MATTER OF THE DISCIPLINARY PROCEEDING REGARDING THE LICENSE TO PRACTICE MEDICINE IN THE STATE OF COLORADO OF GARY MCKINNEY, M.D., LICENSE NUMBER 29138,

Respondent.

This matter came before Hearings Panel A ("Hearings Panel") of the Colorado State Board of Medical Examiners ("Board") for review of the Initial Decision issued by Administrative Law Judge ("ALJ") Judith F. Schulman in the above-captioned case on January 18, 2008. The January 18, 2008 Initial Decision by ALJ Judith F. Schulman is attached as Exhibit 1 and is incorporated herein as if set forth herein.

Inquiry Panel B ("Inquiry Panel") timely filed a Designation of Record and Exceptions to the Initial Decision and a Proposed Final Board Order. Respondent timely filed a Response to the Inquiry Panel's Exceptions to the Initial Decision. On April 10, 2001 and May 21, 2008, the Hearings Panel gave due

consideration to the record as a whole, to the pleadings filed by the parties, and arguments made by the parties. Conflicts counsel from the Office of the Attorney General was present during oral argument and deliberation. After such consideration, the Hearings Panel unanimously enters its Final Board Order ("Order") pursuant to § 24-4-105, C.R.S. as follows:

The Hearings Panel adopts the ALJ's Findings of Fact set forth in the Initial Decision.

The Hearings Panel adopts the ALJ's Conclusions of Law set forth in the Initial Decision.

The Hearings Panel rejects the ALJ's Initial Decision and recommended sanctions. The Hearings Panel finds that the only appropriate sanction to adequately protect the public is to restrict Respondent's license to the office practice of obstetrics and gynecology. Respondent may not engage in the surgical practice of obstetrics or gynecology in a hospital or ambulatory surgical center. The Hearings Panel finds that this restriction on Respondent's license is the only appropriate sanction that would adequately protect the public based on the Findings of Fact and Conclusions of Law set forth in the Initial Decision, and Respondent's pattern of discipline in Colorado, demonstrating a lack of professional judgment and discrepancies involving medical records and Respondent's statements.

Appendix B

This decision becomes final upon mailing, Any party adversely affected or aggrieved by any agency action may commence an action for judicial review before the Court of Appeals within forty-five (45) days after such action becomes effective.

Dated and signed this 21st day of May, 2008.

FOR THE COLORADO STATE BOARD OF MEDICAL EXAMINERS, HEARINGS PANEL A

s/ [illegible]
Member

s/ [illegible]
Member

s/ [illegible]
Member

APPENDIX C — INITIAL DECISION OF THE STATE OF COLORADO, OFFICE OF ADMINISTRATIVE COURTS DATED JANUARY 18, 2008

STATE OF COLORADO
OFFICE OF ADMINISTRATIVE COURTS
633 17th Street, Suite 1300 Denver, Colorado 80202

CASE NUMBER:

ME 2007-0003

COLORADO STATE BOARD OF MEDICAL EXAMINERS,

Petitioner,

vs.

GARY E. MCKINNEY, M.D.,

Respondent.

INITIAL DECISION

This is a disciplinary proceeding brought by the State Board of Medical Examiners ("the Board"), Panel B ("the Panel"), under Part 1 of the Colorado Medical Practice Act, Sections 12-36-101 to 12-36-137, C.R.S. ("MPA"), involving the license to practice medicine of Gary E. McKinney, M.D. ("Respondent"). The Board seeks revocation of Respondent's Colorado license pursuant to Section 12-36-118 of the MPA based on alleged violations of the MPA in the conduct of Respondent's medical practice.

Appendix C

Hearing was conducted on August 21-23, 2007, before Administrative Law Judge Judith F. Schulman, Colorado Office of Administrative Courts. The Panel was represented by Karen McGovern, Assistant Attorney General. Respondent was represented by Lori M. Moore, Esq. The hearing was digitally recorded in Courtroom 2. The Board's Exhibits 1 through 14, 16 and 19 and Respondent's Exhibits A through D and J through O were admitted into evidence.

Preliminary Matters

At the commencement of the hearing, the Panel dismissed paragraphs 19, 20, 22c, 29, 30, 34, 35, 42, and 61a, b, f and g of the Formal Complaint. Thus, with respect to Patient A, all allegations concerning orders for a rectal administration of a Fleet enema were dismissed. With respect to Patient B, all allegations concerning lack of informed consent and failure to communicate with the patient or her husband on the day of surgery were dismissed. Additionally, all allegations concerning the use of a closed, rather than an open, laparoscopic procedure for Patient B were also dismissed.

Also at the commencement of the hearing, Respondent amended his Answer to the Formal Complaint to admit paragraphs 36-38 and 40, which paragraphs he had previously denied.

Appendix C

Exhibit 1

Issues To Be Determined

The Panel asserts Respondent engaged in unprofessional conduct, as defined by the MPA, because his care and treatment of two patients (Patients A and B) failed to meet generally accepted standards of medical practice. The Panel also asserts that Respondent's medical charting with respect to these two patients failed to comply with statutory requirements.

With respect to Patient A, the Panel asserts that during the course of performing an abdominal hysterectomy and bilateral salpingo-oopherectomy, Respondent intentionally severed and removed a portion of the patient's bowel in order to facilitate dissection of a uterine fibroid, in contravention of generally accepted standards of practice. The Panel also asserts that during the course of this surgery Respondent made a surgical incision without adequate visualization. With respect to Patient B, the Panel asserts that in connection with a laparoscopic tubal ligation Respondent failed to prescribe adequate analgesia when the patient was discharged from the ambulatory surgical center. The Panel also alleges Respondent failed to respond to calls made on behalf of the patient regarding postoperative complications and failed to ensure on-call coverage for his patients on the day of Patient A's surgery. Additionally, as noted above, the formal Complaint alleges Respondent's charting with respect to both Patient A and B failed to comply with MPA requirements.

Appendix C

In response to the allegations regarding Patient A, Respondent denies he intentionally entered the Patient's bowel to facilitate dissection of a uterine fibroid during the course of performing a hysterectomy. Instead, Respondent asserts he inadvertently torn a portion of bowel while attempting a blunt dissection of an adherent uterine fibroid. He maintains that his chart entries suggesting he intentionally entered the bowel to facilitate the dissection were erroneously worded. Respondent also asserts he had full visualization prior to making any cuts during the surgery. With respect to Patient B, Respondent asserts his practice of initially prescribing only non-narcotic analgesics to his post-laparoscopic tubal ligation patients is appropriate. He also asserts that he and his office properly responded to the patient's post-surgery calls and that he had appropriate on-call coverage on the day of the patient's surgery. With respect to Patient A, Respondent acknowledges that his charting was inadequate, although not necessarily in violation of statutory requirements. He contends, however, that his charting with respect to Patient B was appropriate.

The issue to be determined in this matter is whether Respondent engaged in unprofessional conduct in violation of the MPA with respect to Patient A and/or Patient B, as alleged in the Formal Complaint and, if so, what sanction, if any, is appropriate.

Appendix C

Findings of Fact

1. Respondent was licensed to practice medicine in the state of Colorado on October 13, 1988, and was issued license number 29138, which Respondent has held continuously since that date.

2. On May 16, 2003, the Panel issued a Letter Of Admonition ("LOA"') to Respondent regarding Respondent's substandard care of an obstetrical patient and discrepancies between the facts contained in the medical records and the facts reported in Respondent's response to the Panel concerning Respondent's care of this patient. The discrepant facts reported by Respondent to the Panel tended to place Respondent's actions in a more favorable light than the matters set forth in the patient's medical records.

3. Respondent has a solo OB-GYN practice in Canon City, Colorado. There is only one other OB-GYN in Canon City, Dr. Staples. Respondent and Dr. Staples share call.

4. In May 2006, the Panel reviewed case numbers 2004-003438-B and 2005-004998-B and referred these cases to the Attorney General pursuant to Section 12-36-118(4)(c)(IV), C.R.S., for disciplinary action. Thereafter, the Attorney General filed a Formal Complaint with the Office of Administrative Courts, alleging Respondent had violated the MPA with respect to his care and treatment of Patients A and B.

Appendix C

Patient A

5. On January 21, 2004, Patient A, a 51-year-old female, presented to Respondent's office with complaints of abdominal pain and previously diagnosed large fibroid[1] uterus. Respondent's notes from that visit indicate he felt the patient had a "large 20 week fibroid uterus."

6. On January 29, 2004, Respondent performed a total abdominal hysterectomy and bilateral salpingo-oopherectomy ("TAH-BSO")[2] on Patient A at St. Thomas More Hospital, Canon City, Colorado. The surgery revealed that Patient A had a very large irregular fibroid uterus, including a pedunculated fibroid[3] beginning at the fundus of the uterus and ending in the posterior cul-de-sac.

7. During the surgery, Respondent discovered that the pedunculated fibroid was adhered to the serosal (outermost) layer of the peritoneum.[4]

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1. A fibroid is a smooth muscle tumor.

2. A total abdominal hysterectomy involves removal of the cervix as well as the uterus. A bilateral salpingo-oopherectomy involves removal of both fallopian tubes and ovaries.

3. A pedunculated fibroid is a fibroid tumor that attaches by means of a stalk.

4. The physicians who testified at hearing differed somewhat in the their definition of the term "peritoneum."

(Cont'd)

8. During the course of the surgery, a large hole was made in the patient's sigmoid colon. Dr. Robert Gross, a general surgeon, was called in to repair the injury. Dr. Gross determined that the colon would not be amenable to suture repair of the hole in Patient A's bowel created by Respondent. Instead, he resected the segment of the colon in question and performed a reanastomosis (cutting away the damaged bowel tissue and sewing the good ends together).[5]

[Bowel Tear Versus intentional Cut]

9. Respondent and all experts who testified agreed that if Respondent intentionally and electively opened the patient's colon to facilitate dissection of the pedunculated fibroid, such action failed to meet the generally accepted standard of medical practice ("standard of care") for an OB-GYN practicing in 2004.

(Cont'd)

Respondent utilized the term to be essentially synonymous with the top layer of the intestine. Respondent's expert, Dr. William Schlaff, testified that the peritoneum is the lining of the pelvis. He stated that while the serosal layer of the intestine is a peritoneal surface, it is not commonly celled the peritoneum. Use of the term in this Initial Decision for the most part tracks Respondent's usage of the term in his testimony.

5. The patient experienced several additional complications following this repair that were not attributable to Respondent and are not at issue in this proceeding. The patient was transferred to St. Mary Corwin Hospital in Pueblo, Colorado, on February 1, 2004, for treatment of those postoperative problems.

Instead, as agreed by all witnesses, the applicable standard of care for an OB-GYN who, during the course of a hysterectomy, encounters adhesions[6] between a uterine fibroid and the colon is to attempt to separate the two adherent structures by means of blunt dissection.

10. After the procedure, the following chart entries were made relating to this procedure:

a. Operative report, dictated by Respondent on January 29, 2004, the same day as the surgery (Exhibit 1, p. McKin 1579). In the report, Respondent identified the "procedures performed" as "TAH-BSO and opening the sigmoid colon to facilitate dissection." Additionally, in the "description of procedure" portion of the report, Respondent noted: "[o]nce the uterus was removed, in order to remove the large fibroid in the posterior cul-de-sac that was attached to the large bowel, the bowel had to be opened and removed."

b. Progress note, handwritten by Respondent on January 29, 2004, describing the operative procedure (Exhibit 1, p. McKin 1547), in which Respondent described his findings as "multiple fibroids involving the large bowel" and noted "complica[tions] = 0."

c. Discharge summary/transfer note dictated by Respondent on February 1, 2004 (Exhibit 1, p. McKin 1527). In this report Respondent stated: "This is a 51-

6. An adhesion is an abnormal connection between two surfaces.

year-old white female who currently underwent total abdominal hysterectomy and BSO for a large fibroid uterus. This uterus grew down into the large intestines and adhered around the large intestines. In order to facilitate dissection, the large intestines were opened, severed, and removed along with the specimen."

d. Additionally, an operative report of the general surgeon, Dr. Gross, which was dictated on January 30, 2004, (Exhibit 1, p. McKin 1581), notes under the heading "indications:" "It was reported by Dr. McKinney during this procedure that he encountered an adherent uterine fibroid tumor to the colon which necessitated dissecting this portion of the colonic wall to facilitate the removal of the fibroid uterus. This resulted in a large perforation of the colon."

e. Respondent made no chart entries specifically stating that any complications occurred during Patient A's surgery.

11. The pedunculated fibroid in this case was approximately the size of a softball, measuring approximately 13 x 10 x 10 cm.

12. As acknowledged by Respondent's expert, adhesions such as those present in the case of Patient A are always surface to surface; there is virtually no circumstance in which the patient's fibroids would have eroded through the superficial layers of the colon to evade the lumen of the bowel.

Appendix C

13. An inadvertent bowel tear is a known potential complication of a hysterectomy. Such tears can occur even when the procedure is performed carefully and within generally accepted standards of medical practice.

14. Respondent agrees that inadvertently tearing the bowel while performing a hysterectomy would constitute a complication of surgery.

15. Complications of surgery are essential chart entries. Respondent conceded at hearing that an inadvertent bowel tear that occurs during a hysterectomy should be charted as a complication in the patient's record, including the operative report.

16. At hearing, Respondent asserted that contrary to his chart entries, which he contended were erroneously worded, he did not electively and intentionally enter the patient's bowel to complete dissection of the fibroid. Instead, he asserted that the following occurred:

Respondent opened the patient's abdomen, removed the supporting ligaments, and thought that he had freed the cervix, the uterus, and the ovaries. However, at this point he discovered that the uterus was still stuck in the cul-de-sac as a result of a pedunculated uterine fibroid which he believed was adherent to the serosal layer of the peritoneum.[7] Respondent asserts

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7. The fibroid was in fact adherent through the serosal layer to the surface of the attached bowel below. However, Respondent conteends that at this point he had no way of knowing this was the case.

hg then tried, through blunt dissection, to find a plane between the fibroid and the peritoneum by attempting to push his thumb or finger between the two structures to separate them. This effort was unsuccessful and, instead, Respondent inadvertently tore the patient's bowel, creating a semi-circular opening in the lumen of the colon, described by Respondent as being approximately the size of a fingernail or 1.5 cm x 1.0 cm. According to Respondent, at this point the resulting torn portion of the bowel remained attached to the bowel in a bunched-up jagged line at the far end of the tear and the fibroid was still attached to the patient's bowel immediately past the torn portion of the bowel.

Respondent asserts he immediately recognized a tear had occurred. He called for the general surgeon, Dr. Gross, who was in the next operating room, to perform a repair. Meanwhile, the patient was bleeding profusely. According to Respondent's hearing testimony, after calling for the general surgeon Respondent decided to cut the portion of the patient's bowel to which the fibroid remained adherent, along with the contiguous torn portion of the bowel, thereby completing the dissection of fibroid and allowing the cervix, uterus and ovaries (as well as the attached fibroid) to be removed. Respondent asserts this action allowed him to make a clean cut and to pack the colon and stop the bleeding while awaiting the general surgeon's repair. According to Respondent, the resulting hole on the top of the patient's bowel formed by Respondent intentionally cutting around the area of attachment (the circumference of the adherent fibroid)

was approximately 3.0 cm x 1.7 cm, described as the size of a golf ball.

Thus, Respondent contended at hearing it was only after an inadvertent tear had occurred that he proceeded to cut the additional portion of the bowel with a scissors, thereby freeing the fibroid and assisting with control of the patient's bleeding. Respondent maintains he took this action because he knew the tear could not be repaired by mere suturing but instead would require, at a minimum, a reanastomosis. Respondent reasoned that the portion he cut would have had to have been removed by the general surgeon in any event in connection with the required surgical repair of the bowel. Respondent explained his chart entries as simply drafting errors in which reference to the tear was mistakenly omitted.

17. The only individual other than Respondent who was present at Patient's A's hysterectomy and who testified at hearing was Gary Mohr, M.D., a family practitioner, who assisted in the surgery. Dr. Mohr testified that while assisting in the surgery, he was located on the right side of the patient and that the pedunculated fibroid, which was approximately 3 inches in diameter, was primarily on the patient's left side on top of the uterus and near the back of the uterus. Dr. Mohr indicated that his job during surgery was to manipulate the uterus by means of a Robert's screw, placed in the uterus by Respondent, in order to assist Respondent with visualization. As testified by Dr. Mohr, after all the structures were severed and ligated, he

attempted to lift the uterus away from the abdomen by raising the Robert's screw, but he found the uterus was still stuck. Shortly thereafter, Respondent asked for and used a Jorgenson scissors (curved to cut behind structures) to cut something. Immediately after Respondent made the cut, the uterine specimen, consisting of a single piece of tissue containing the uterus, tubes, ovaries and fibroids (with the Robert's screw still attached) was freed and Dr., Mohr was able to lift the specimen out of the patient's abdomen and place it in a sterile basin, to be sent to pathology. According to Dr. Mohr, within seconds after Respondent used the scissors, Dr. Mohr was able to smell stool. Dr. Mohr recalled that either he or Respondent acknowledged the smell by stating "you know what that means," thus indicating an awareness that the colon had been entered. According to Dr. Mohr, it was at this point, after Dr. Mohr had passed off the specimen, that Respondent called for the general surgeon to perform the repair. Dr. Mohr testified that a period of one to two minutes elapsed between the time Dr. Mohr determined the uterus was still stuck until he handed off the freed specimen. Dr. Mohr testified that from his vantage point and because of the duties he was performing he was never able to visualize where the fibroid rested against the sigmoid colon or exactly what Respondent was doing while Dr. Mohr was trying to lift the uterus up. Dr. Mohr confirmed that the hole in Patient A's bowel following Respondent's actions was approximately the size of a golf ball.

Appendix C

18. Although there are some discrepancies between Respondent's version of the surgical events and Dr. Mohr's version (for example, whether Respondent asked for the general surgeon before or after he cut with the scissors), the ALJ finds Dr. Mohr's testimony does not significantly assist in determining whether Respondent intentionally entered the patient's bowel in order to facilitate dissection of the fibroid, as asserted by the Panel, or whether Respondent first inadvertently tore a hole in the patient's bowel while trying to dissect the fibroid and only later intentionally cut the bowel, as asserted by Respondent, Dr. Mohr's description of what he observed (or could not observe) during the surgery is reasonably consistent with either version of events.

19. The ALJ nonetheless finds that during the surgery Respondent did intentionally open, sever, and remove a portion of Patient A's bowel to facilitate dissection of the fibroid. This finding is based in large part on the medical records in this matter. In particular, Respondent's January 24, 2004 dictated operative report listed the procedure he performed as a "TAH-BSO and opening the sigmoid colon to facilitate dissection" and noted that once the uterus was removed, in order to remove the large fibroid that was attached to the large bowel, "the bowel had to be opened and removed." Similarly, Respondent's discharge/transfer note of February 1, 2004, states that "[i]n order to facilitate dissection, the large intestines were opened, severed, and removed along with the specimen." These entries do not merely omit mention of an unintentional tear, as asserted by Respondent; they affirmatively

indicate that the bowel *had* to be opened to facilitate the dissection. Yet, if an inadvertent tear had occurred, as Respondent contends, there would have been no need to *open* the bowel to facilitate the dissection; the bowel would have already been opened as a consequence of the tear. Respondent's choice of wording in these two entries thus indicates he made an intentional choice to open the patient's bowel for the purpose of dissecting the fibroid; the wording cannot be explained as simply a drafting error by omission.

Two other chart entries support a determination that Respondent did not simply choose his words improvidently but instead intentionally and electively opened the patient's bowel to facilitate the fibroid dissection without any unintentional tear having first occurred. The first of these is Dr. Gross' January 30, 2004 operative report, which notes that Respondent reported he "encountered an adherent uterine fibroid tumor to the colon which necessitated dissecting this portion of the colonic wall to facilitate the removal of the fibroid uterus." Thus, like Respondent's chart entries, Dr. Gross' entry makes no reference to Respondent having reported an initial inadvertent tear in the bowel. At hearing, Respondent did not assert that Dr. Gross' entry was the result of any misunderstanding on the part of Dr. Gross regarding Respondent's chart entries. Nor did he assert Dr. Gross misunderstood any statements made by Respondent to Dr. Gross. In fact, Respondent never denied Dr. Gross' charting fully and accurately reflected the information Respondent communicated to Dr. Gross concerning the procedure.

It is therefore reasonable to conclude Respondent never informed Dr. Gross of any inadvertent tear, a fact that provides additional circumstantial evidence that no such tear ever occurred, Thus, Dr. Cross' operative report further supports a determination that Respondent's decision to cut the bowel was not a response to an initial inadvertent tear, but instead constituted an intentional decision to electively enter the patient's bowel to facilitate dissection of the fibroid without any initial inadvertent tear.

The final chart entry that supports a determination Respondent intentionally and electively entered the patient's bowel is Respondent's January 29, 2004 handwritten progress noteconcerning the surgery in which he noted "complica[tions] = O." Although Respondent maintained at hearing that this entry was a mistake on his part, there is simply no reasonable explanation for this entry other than a determination that no initial tear ever occurred. Respondent agreed at hearing that a bowel tear during a hysterectomy would constitute a complication of surgery. In this case, Respondent did not merely omit charting such a complication (as was the case with his dictated operative note and discharge/transfer note); he affirmatively indicated no complication had occurred. Such an entry, particularly because it was handwritten by Respondent contemporaneously with the surgery, can only be explained by concluding no inadvertent tear in fact occurred and by further concluding that cutting the bowel to facilitate the dissection of the fibroid was an intentional and planned part of Respondent's surgical procedure once he discovered the fibroid was adhered to the patient's sigmoid colen.

In addition to these charting issues, the ALJ notes that during the course of the hearing Respondent drew a demonstrative diagram that purported to explain what transpired during the surgery (Exhibit O). The diagram and accompanying testimony suggested that Respondent cut a full circle in the bowel, rather than just the semi-circular portion of the bowel beyond the tear to which the fibroid was still adhesed. Respondent's accompanying testimony also suggested that the cut was made in part to even out the ragged edges of the tear. This aspect of Respondent's diagram and testimony was later explained as a mere error, and, in fact, it was inconsistent with the majority of Respondent's hearing presentation, as well as the pathology report, The ALJ finds, however, these errors suggest a lack of clarity by Respondent at the time of hearing as to exactly what transpired at the time of the surgery, in contrast to his more reliable contemporaneous charting of the events in question.

The ALJ also notes that in his answer to paragraph 16 of the Formal Complaint Respondent admitted the following allegation: "After removing the fibroid uterus and a portion of Patient's (*sic*) A's bowel, Respondent called a general surgeon in to the surgery to repair the injury to the bowel." This version of events, which Respondent admitted through counsel on May 1, 2007,[8]

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8. As noted in the "Preliminary Matters" section of this decision, at the commencement of the hearing Respondent changed three of his Formal Complaint answers from denials to admissions, thus indicating a recent review of the answer had occurred. No amendment to Respondent's answer to paragraph 16 was offered at that time or thereafter.

differs from the chronology Respondent testified to at hearing because it indicates Respondent called for the general surgeon after he removed the fibroid uterus and a portion of the patient's bowel. In contrast, at hearing Respondent explicitly testified he called for a general surgeon immediately after he recognized he had torn the bowel, *before* he cut the patient's bowel to remove the adherent fibroid.[9] This discrepancy provides an additional indication that Respondent's explanation of events has evolved over time. The ALJ finds his current recollection is likely to be less reliable than the version he charted contemporaneously with the events in question.

20. Respondent's action in intentionally and electively opening, severing, and removing a portion of

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9. Because the admitted paragraph 16 indicates Respondent called for a general surgeon after *removing* the fibroid uterus and a portion of the patient's bowel, the admission cannot be construed as consistent with Respondent's assertion at hearing that he called for a the general surgeon as soon as the tear occurred and before he did any intentional cutting. As described in Respondent's testimony, the tear did not result in the *removal* of any bowel or uterine tissue but instead resulted in the bunching up of tissue that was still attached to the bowel; no tissue removal occurred until later, when Respondent intentionally cut the bowel. Thus, according to Respondent's version of events as testified to at hearing, no removal of tissue occurred prior to calling for the general surgeon. Consequently, Respondent's admission to paragraph 16 indicating he called for the general surgeon after removing the fibroid uterus and a portion of the patient's bottlenecks consistency with his testimony at hearing.

Appendix C

Patient A's bowel to facilitate dissection of the fibroid failed to meet generally accepted standards of medical practice for an OB-GYN in 2004.

[Further Findings Concerning the Surgery]

21. After dissecting the fibroid, Respondent sent a fresh specimen, consisting of the uterus, adnexa, and fibroid with attached bowel tissue to pathology. A pathology report indicates that the size of the excised bowel tissue was approximately 3.0 cm x 1.7.

22. Dr. Gross' operative note concerning his bowel repair with respect to Patient A indicates that upon examination of the patient's abdomen he found a "large perforation of the sigmoid colon 7 cm in length and encompassing approximately 80% of the diameter of the colon." Respondent denies that the bowel injury was this large, instead asserting the hole created by his inadvertent tear followed by his intentional cutting away of the portion of the patient's bowel to which the fibroid remained adherent, was approximately 3.0 cm x 1.7 cm in total size, as reflected in the pathology report describing the specimen sent by Respondent. Dr. Gross did not testify at hearing. The record contains no explanation for the discrepancy between the pathology report measurements and Dr. Gross' description of the bowel injury he found upon being called in to perform the repair.

23. The record supports a determination that Respondent opened an area of Patient A's bowel the size

of a golf ball, measuring approximately 3.0 cm x 1.7 cm. It does not support a determination that Respondent opened an area measuring approximately 6-7 cm in length and encompassing approximately 80% of the circumference of the bowel.

24. The discrepancy in the evidence concerning the size of the hole in Patient A's bowel is net a significant factor in determining whether Respondent intentionally and electively opened the patient's bowel.

25. There was no suggestion during or in advance of the procedure that the pedunculated fibroid was malignant.

26. The pathology report in this case confirmed that the patient's fibroid was adhered to, but had not invaded, the colon. The pathology report additionally confirmed that the fibroid was benign.

[Visualization]

27. Respondent asserts he had full visualization throughout Patient A's hysterectomy procedure.

28. The Board's expert testified that in light of the size of the pedunculated fibroid, the fact that it was adhered to the sigmoid colon which is on the left side, the Respondent's operating room position at the patient's right side, and the fact that Respondent did not perform a myomectomy (surgical excision of the fibroid) or cut away portions of the fibroid to have a

better view, it is likely that Respondent did not have good visualization during the surgery. However, the Board's expert was not present at the surgery and thus was not in a position to know exactly what Respondent was actually able to see during the surgery.

29. Although Dr. Mohr was reported to have indicated in pre-hearing proceedings that Respondent "cut blindly" with a scissors during the procedure, at hearing Dr. Mohr did not so testify. To the contrary, Dr. Mohr testified that during the procedure Respondent instructed Dr. Mohr to move the uterus (by means of the Robert's screw) in various ways to enhance visualization. Dr, Mohr also testified Respondent never indicated he couldn't visualize the surgical field. Dr. Mohr stated that based on his past experience in assisting Respondent in surgery, he believes Respondent would have asked if he needed something done to improve visualization. Dr. Mohr further testified that based on his own positioning and tasks during surgery, he does not know what Respondent was able to see during the procedure.

30. The record does not support a determination that Respondent lacked full visualization during Patient A's hysterectomy.

[Additional Findings]

31. The parties dispute whether Respondent's actions, if they occurred as asserted by Respondent (Respondent only acted cintentionally cut the patient's

bowel after an inadvertent tear occurred) would fall within generally accepted standards of medical practice. Because the ALJ has determined no inadvertent tear occurred, the ALJ declines to reach this issue.

32. If, contrary to the AU's findings in this matter, an inadvertent tear of Patient A's bowel occurred during surgery, such development would have constituted a complication and documentation of such event would be an essential chart entry. Further, the failure to document this event would have rendered Respondent's charting inaccurate. Under such circumstances, Respondent's failure to document the event in his handwritten operative note, his dictated operative note, and his discharge/transfer note would constitute repeated incorrect entries and repeated failures to make essential entries on patient records. Additionally, Respondent's entry in his handwritten operative note that no complications had occurred would constitute a false and incorrect chart entry.

Patient B

33. On or about February 14, 2005, Patient B, a 33-year-old female, presented to Respondent requesting sterilization.

34. On March 1, 2005, at approximately 10:00 a.m., Respondent performed a closed laparoscopic tubal ligation using electrocautery on Patient B at the Pueblo Surgery Center (PSC), an ambulatory surgical facility in Pueblo, Colorado.

35. During the surgery Respondent made four separate attempts to enter Patient B's abdomen.

36. Respondent did not document in the PSC progress notes or operative note relating to this surgery that he had made four separate attempts to enter Patient B's abdomen. He also did not document these attempts in his office medical records for the patient.

37. Perforation of the bowel is a known potential risk of a laparoscopic tubal ligation procedure. Such perforations can occur even when the procedure is performed carefully and within generally accepted standards of medical practice.

38. Patient B sustained two bowel punctures during this surgery, however this complication was not recognized at the time of surgery.

39. Respondent did not speak with Patient B post-operatively on March 1, 2005.

40. After Patient B's surgery, Respondent went home to sleep, having been up all night the night before. Respondent conceded at hearing that he was "unavailable" for the remainder of the day following the March 1, 2005 surgery. Respondent did not inform Patient B or her husband (who accompanied Patient B to PSC on the day of surgery) that he would be unavailable fallowing the surgery.

Appendix C

41. In the post-operative recovery room at PSC following the March 1, 2005 surgery, Patient B was difficult to console and complaining of pain. She was given a total of 200 micrograms of IV Fentanyl, a narcotic, for her pain over a span of a little more than two hours in the recovery room.

42. Pursuant to Respondent's standing orders for post-operative laparoscopic tubal ligation patients, Patient B was discharged home from the PSC recovery room with instructions to take Advil, Tylenol, or Aleve for post-operative pain. Respondent did not prescribe or provide any narcotic pain medication post-operatively for Patient B upon discharge.

43. Respondent asserts he does not prescribe narcotics for his post-operative laparoscopic tubal ligation patients upon discharge from the ambulatory surgery center because such medication can mask pain, a potential indication of a complication. He therefore tells patients to take Advil, Tylenol, or Aleve and call him if their pain is not controlled with these medications. Respondent believes that this approach assures that he will be promptly notified of any indications of potential post-operative complications. Respondent acknowledges that Advil, Tylenol and Aleve can mask a fever, which is a sign of an infection and may indicate a complication has occurred.

44. Patient B was discharged from PSC at approximately 2:00 p.m. Her husband drove her home to Canon City, a trip that takes approximately 30-40

minutes. Patient B was in some pain and was nauseous on the way home.

45. After arriving home, Patient B took Tylenol in response to increasing pain. However, due to her ongoing nausea she was unable to keep the Tylenol down. Patient B then asked her husband to contact Respondent's office.

46. The parties dispute exactly what occurred thereafter. After considering all the evidence, the ALJ finds that at approximately 3:30 p.m. Patient B's husband initiated a series of three or four calls to Respondent's office. He was unable to speak with Respondent and instead spoke with one of Respondent's employees. Patient B's husband informed Respondent's employee that Patient B had just had surgery, was experiencing increasing pain, and wanted something stronger for pain to cover her for the night. Respondent's employee informed Patient B's husband that Respondent was not in the office and would be unavailable until the following morning. The employee informed Patient B's husband that Dr. Staples, the other OB-GYN in Canon City, would be on call starting at 5:00 p.m. Patient B's husband then called Dr. Staples' office to see if Dr. Staples could see Patient B, but was informed by the doctor's staff that Dr. Staples was not on call until 5:00 p.m. and could not see Patient B until then. Pr. Staples' staff indicated that if Patient B wished to go to the emergency room, he could potentially meet her there after 5:00 p.m. Patient B's husband then called back to Respondent's office to inform the staff of Dr.

Staples' unavailability, During one of the calls to Respondent's office, Respondent's staff informed Patient B's husband that they could provide a prescription for nausea medication but not for narcotic pain medication. A prescription for Phenergan was ultimately called into the pharmacy by Respondent's staff and Patient B's husband was so notified by a staff member.[10]

47. Respondent testified that on the afternoon of March 1, 2005, he received a call at home from his staff informing him that Patient B was requesting nausea medication only, in response to which he approved a Phenergan prescription to control Patient B's nausea. Respondent stated that he specifically remembers this telephone conversation because it was unusual for a patient to request only nausea medication and not pain medication. However, the ALJ finds that Respondent's version of these events is inconsistent with the weight of the evidence. As reflected by the testimony of both Patient B and her husband, and as substantiated in significant part by subsequent medical records, Patient B's husband informed Respondent's staff over the course of a series of three or four conversations during the afternoon of March 1, 2005, that Patient B was

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10. This version of events is consistent with Respondent's testimony that his staff is authorized to call in Phenergan prescriptions without his prior approval if they feel comfortable doing so or they may also seek his prior approval for such prescriptions. It is also consistent with Respondent's testimony that his staff is not authorized to call in prescriptions for narcotics on their own.

experiencing increasingly severe pain and that she wanted a prescription for pain medication, as well as nausea medication. Because it is unlikely that Respondent's staff would have taken these calls and yet reported only Patient B's complaints of nausea to Respondent, and because Respondent has acknowledged that he was, in fact, unavailable during the afternoon of March 1, 2005, the ALJ finds that the Phenergan prescription was provided to Patient B by Respondent's staff pursuant to a standing authorization and without consulting Respondent. Additionally, Respondent's assertion that he was consulted by his staff concerning the Phenergan prescription is inconsistent with Respondent's contention at hearing that Dr. Staples was actually covering for him on the afternoon in question.

48. Because Patient B's pain was continuing to get worse, at approximately 5:00 p.m. on March 1, 2005, Patient B's husband took her to the St. Thomas More Hospital (STMH) emergency room. The emergency room physician noted that Patient B was complaining of mild nausea and intolerable pain and was unable to contact Respondent. Patient B was medicated for severe abdominal pain and discharged from the emergency department at 6:25 p.m.

49. Patient B returned to the STMH emergency department at approximately 1:00 a.m. on March 2, 2005, with complaints of severe abdominal pain, She was admitted to STMH by the on-call physician at approximately 3:40 a.m. on March 2, 2005.

Appendix C

50. At approximately 9:30 a.m. on March 2, 2005, Respondent examined Patient B for the first time since the tubal ligation surgery the previous day, He ordered a pelvic and abdominal ultrasound, among other tests. Additionally, he noted in his March 2, 2005 progress note "diff entry yesterday requiring 4 sticks."

51. On March 3, 2005, Respondent noted he observed the patient had developed a subumbilical hematoma with possible blood in the cul-de-sac. He recommended that the patient undergo an exploratory laparotomy and noted the possibility of a bowel perforation.

52. Respondent performed an exploratory laparotomy on Patient B later in the day on March 3, 2005, at which time he discovered Patient B's bowel had been perforated. Respondent called in a general surgeon to perform the repair, which was accomplished by means of a segmental resection with primary reanastomosis. Patient B was treated with antibiotics and discharged on March 8, 2005 with no further complications.

53. Respondent has shared call with Dr. Staples for a number of years. Their arrangement is that on weekdays call starts at 5 p.m. and continues until 7 a.m. the next morning. It was conceded at hearing that March 1, 2005, the day of Patient B's surgery, was a weekday and was governed by the weekday call schedule. Dr. Staples was on call the night of March 1-2, 2005.

54. Respondent and Dr. Staples also have a standing arrangement that if one of them can't be reached during non-call times the other will cover for him, if available.

55. When Respondent left PSC on March 1, 2005 to go home to bed, he did not make any attempt to communicate with Dr. Staples or his staff, Respondent did not inform Dr. Staples that Respondent would be unavailable for the remainder of the day and did not inform Dr. Staples that he had a fresh post-operative patient who required coverage, At hearing, Respondent explained this omission in part by asserting has did not plan to be unavailable. He also relied on his standing coverage arrangement, but on further questioning conceded that he did not, in fact, know whether Dr. Staples was available to cover for him for the remainder of the day on March 1, 2005, until official call began at 5:00 p.m.

56. Respondent also justified his actions by indicating that when Patient B's husband called Dr. Staples' office and indicated his wife was having post-operative pain, he was instructed to take Patient B to emergency room. Respondent asserted this was appropriate advice and is consistent with his own on-call procedure when one of Dr. Staples' post-operative patients calls complaining of pain. Respondent noted that while each situation is individualized, it is normally his judgment to have the patient evaluated in the emergency room. Specifically he noted: "If she's sick enough after he's done surgery on her she'll go to the

emergency room and won't raise hell about waiting four to six hours because to her it's worth it, she's in pain. If it's not enough pain for her to go in and wait four to six hours, she's not going to do it, she's going to call Dr. Staples in the morning."

57. Patient B and her husband were unable to reach either Respondent or Dr. Staples on the afternoon of March 1, 2005, despite multiple calls to Respondent's office and a call to Dr. Staples' office.

58. Respondent failed to arrange for and assure coverage of his practice on the afternoon of March 1, 2005, when he was unavailable and had a fresh post-operative patient.

59. At hearing, Respondent challenged the version of events presented by Patient B and her husband, suggesting that their testimony was affected by animosity toward Respondent that subsequently developed in response to Patient B's post-operative complications. However, contemporaneous hospital records created before the full nature of Patient B's post-operative complications became apparent support the accuracy of the challenged testimony. In particular, STMH emergency department records from March 1, 2005 (Exhibit 5 McKin 0262) and PSC post-operative follow-up notes from March 2, 2005 (Exhibit 4 McKin 0291-0292) support assertions by Patient 8 and her husband that during the afternoon of May 1, 2005 following the surgery Respondent was unavailable, Patient B was unable to obtain requested pain

medication from Respondent or see him, and Dr. Staples was unavailable. Specifically, the emergency room record from March 1, 2005 indicates the patient reported she was "unable to contact surgeon, Dr. McKinney." The PSC follow-up notes, reflecting information obtained from Patient B's husband, indicate the patient "contacted Dr. McKinney but he wouldn't see her," and was given only "Aleve and Tylenol" for pain. The PSC notes also state: "contacted McKinney 4 p.m. Nurse sd had rest of day off. Could order Phenergan but wouldn't see her until in the am. Sd Staples was covering [after] 5 p.m." The notes also indicate Patient B went to the emergency department because of severe pain.

60. Although the Panel's expert initially opined that it is essential to chart the number of attempts that have been made to enter the abdomen during a laparoscopic tubal ligation, he ultimately agreed that charting such information is not essential. He further stated that such charting is not required by generally accepted standards of medical practice. No expert testimony in the record supports a contrary determination.

61. Commonly, OB-GYNs do not document the number of such attempts made to enter the abdomen during a laparoscopic tubal ligation. The fact that Respondent did not document this information in the PSC records or his office records but did include the information in Patient B's chart when she was hospitalized at STMH, does not support a determination that charting such information was essential.

Appendix C

62. Respondent did not repeatedly fail to make essential entries on Patient B's records or act in a manner inconsistent with generally accepted standards of medical practice when he initially did not document his repeated attempts to enter Patient B's abdomen during her March 1, 2005 laparoscopic tubal ligation at PSC.

63. Typically, individuals who undergo a laparoscopic tubal ligation. experience significant post-operative pain. Such pain generally cannot be controlled merely with Tylenol, Advil or Aleve. It is therefore a common, and essentially universal, practice for OB-GYNs to prescribe oral narcotic medications to control post-operative pain following a laparoscopic tubal ligation.

64. In 2005, the generally accepted standard of medical practice required an OB-GYN to prescribe a reasonable amount of oral narcotic pain medication for control of surgical pain following a laparoscopic tubal ligation. To the extent Respondent's expert opined no standard exists one way or the other with respect to prescribing post-operative narcotic analgesic medications in this circumstance, the ALJ finds such testimony was unconvincing, particularly in light of the fact that both the Panel's expert and Respondent's expert were unaware of any OB-GYN (other than Respondent) who does not prescribe oral narcotic pain medication to post-surgical laparoscopic tubal ligation patients.

Appendix C

65. Respondent's practice of prescribing only Tylenol, Advil, or Aleve for pain following laparoscopic tubal ligations and instructing patients to call Respondent if such medication did not control the patient's post-operative pain constituted a failure to prescribe adequate analgesia to Respondent's such patients and failed to meet the generally accepted standard of medical practice for an OB-GYN in 2005, even if the purpose of such practice was to assure indications of a complication were not masked by narcotic medication Respondent.

66. With specific reference to Patient B, Respondent's action in prescribing only Tylenol, Advil or Aleve for Patient B's pain following her March 1, 2005 laparoscopic tubal ligation and instructing Patient B to call Respondent if such medication did not control her post-operative pain constituted a failure to prescribe adequate analgesia for Patient B upon her discharge from PSC on March 1, 2005 and failed to meet the generally accepted standard of medical practice for an OB-GYN in 2005.

67. In 2005, the generally accepted standard of medical care required an OB-GYN to ensure on-call coverage for the OB-GYN's patients. As agreed by both the Panel's expert and Respondent's expert, this standard requires that the physician be personally available to his patients or assure coverage by a qualified individual at all times. Further, it is not sufficient merely to have emergency room back up.

Appendix C

68. During the afternoon of March 1, 2005, although Respondent's staff was available to respond to calls placed by Patient B and/or her husband and provided a prescription for Phenergan to Patient B, Respondent was unavailable to see Patient B or to provide her with a prescription for narcotic pain medications and failed to provide or assure coverage of his practice by another physician.

69. Respondent's actions in March 1, 2005, in being unavailable to his patients and not assuring on-call coverage by another physician, and, in particular, Respondent's unavailability to Patient B without having assured Dr. Staples was available for coverage from 3:30 p.m. until 5:00 p.m. (when Dr. Staples' formal on-call responsibilities began), failed to meet generally accepted standards of medical practice at that time.

70. The evidence did not establish the existence of a definitive standard of care, separate from the issue of ensuring on-call coverage, with respect to when a physician (as opposed to his staff) must respond to calls regarding post-operative complications.

Additional Finding

71. At hearing, Respondent did not indicate he has altered, or believes he should alter, his practice in any way as a result of the events at issue in this proceeding. Respondent offered no evidence of any factors in mitigation.

Appendix C

Discussion and Conclusions of Law

The Formal Complaint alleges Respondent engaged in unprofessional conduct and violated the MPA in connection with his care and treatment of Patients A and B by engaging in acts or omissions which failed to meet generally accepted standards of medical practice, contrary to Section 12-36-117(1)(P), C.R.S., and by falsifying or repeatedly making incorrect essential entries or repeatedly failing to make essential entries on patient records, in violation of Section 12-36-117(1)(cc), C.R.S.

In a proceeding under the MPA alleging the failure of a physician to conform to generally accepted standards of medical practice, the issue is whether the physician exercised the same degree of knowledge, skill and care as exercised by other reasonably careful physicians in the same or similar circumstances. *State Board of Medical Examiners v. McCroskey*, 880 P.2d 1188 (Colo. 1994) ("*McCroskey*"); *Melville v. Southward*, 791 P.2d 383 (Colo. 1990); *Kibler v. State*, 718 P.2d 531(Colo. 1986): *Artist v. Butterweck*, 426 P.2d 559 (Colo. 1967); *see Lee v. State Board of Dental Examiners*, 654 P. 2d 839 (Colo. 1982).

In this case, ALJ has made findings concerning the generally accepted standards of medical practice (also referred to as the "applicable standard of care") and the manner in which Respondent conformed or failed to conform to those standards. These findings, along with the ALJ's findings concerning charting issues, are

applied to the charges contained in the Formal Complaint and the requirements of the MPA, as set forth below.

Patient A

The Formal Complaint alleges that in the course of performing a total abdominal hysterectomy and bilateral salpingo-oopherectomy on Patient A on January 29, 2004, Respondent severed and removed a portion of Patient A's bowel in order to facilitate dissection of a uterine fibroid, which action failed to meet generally accepted standards of medical practice and constituted unprofessional conduct in violation of Section 12-36-117(1)(p). The Formal Complaint also alleges Appellant engaged in substandard conduct during this surgery because he made a surgical incision without adequate visualization. Also with respect to Patient A, the Formal Complaint asserts Respondent's charting violated Section 12346-117(1)(cc).

Inadvertent Tear Versus Intentional Cut. The primary issue concerning this patient is a factual one. The Formal Complaint asserts Appellant intentionally cut Patient A's bowel to facilitate dissection of a uterine fibroid during the course of a TAH-BSO and that such action constituted substandard medical practice. It is undisputed that on January 29, 2004, Respondent performed a TAH-BSO on Patient A and that during the course of that procedure a large hole was made in the patient's sigmoid colon. The parties and their experts agreed at hearing that if Respondent intentionally and electively opened the patient's colon to

facilitate dissection of the patient's pedunculated fibroid, such action failed to meet generally accepted standards of medical practice for an OB-GYN practicing in 2004. The applicable standard of care in 2004 instead required an OB-GYN who encountered adhesions between a uterine fibroid and the colon during the course of a hysterectomy to attempt to separate the two adherent structures by means of blunt dissection.

Respondent contends he did not electively and intentionally enter the patient's bowel to complete dissection of the fibroid. Instead, he asserts he inadvertently tore a hole in the patient's bowel while attempting a blunt dissection. He further maintains that it was only after the inadvertent tear had occurred that he intentionally cut the bowel to complete the dissection and assist in controlling the patient's bleeding. However, for the reasons detailed in the findings of fact, the ALJ has found, contrary to Respondent's assertions, that during the course of the surgery Respondent intentionally opened, severed, and removed a portion of Patient A's bowel to facilitate dissection of the fibroid without any inadvertent tear having first occurred. Such action constituted conduct that failed to meet generally accepted standards of care for an OB-GYN in 2004 and therefore constituted unprofessional conduct as defined in Section 12-36-117(1)(p), C.R.S., as alleged in the Formal Complaint.[11]

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11. Because the ALJ has concluded that no inadvertent tear occurred, the ALJ has not addressed the question of whether Respondent's purported course of action (intentionally cutting the bowel only after an inadvertent tear had occured) would have been consistent with applicable standards of care.

Appendix C

Visualization During Surgery. The Formal Complaint additionally alleges Respondent failed to meet applicable standards of medical practice during the January 29, 2004 TAH-BSO, in violation of Section 12-36-117(1)(p), by making a surgical incision without adequate visualization of the entire surgical field. The ALJ has determined the evidence failed to establish Respondent lacked full or adequate visualization during the surgery. Therefore, the Panel has failed to establish any violation of the MPA occurred in connection with Respondent's visualization during this surgery.

Charting. The Formal Complaint also alleges that to the extent Respondent's explanations of his thought processes, discussions, medical reasoning and/or medical practice are inconsistent with his documentation in patient A's records, such documentation constituted falsifying or repeatedly making incorrect essential entries or repeatedly failing to make essential entries on patient records, in violation of Section 12-36-117(1)(cc), C.R.S. Specifically, the Panel alleges that if an inadvertent tear of Patient A's bowel occurred in this case, as asserted by Respondent, Respondent's charting violated this provision of the MPA because the tear represented a complication and was thus an essential entry, which Respondent failed to chart. At hearing, Respondent defended against assertions of substandard care with respect to dissecting Patient A's fibroid by contending his charting in connection with this case was substantially flawed and did not accurately reflect what actually occurred during the surgery. He also agreed in testimony that a bowel tear during a hysterectomy

would constitute a surgical complication that should be charted in the patient's medical records. Thus, although Respondent's counsel argued in closing that a bowel tear is not an essential entry, Respondent appears to have effectively conceded that under his version of the facts his charting with respect to Patient A violated this section or, at a minimum, was seriously inadequate.

The ALJ has found, however, that contrary to Respondent's assertions, Respondent's charting accurately reflected what actually occurred in this case: no inadvertent tear occurred and Respondent intentionally and electively opened, severed, and removed a portion of Patient A's bowel to facilitate dissection of the patient's fibroid. Thus, Respondent did not make incorrect essential entries or fail to make essential entries in connection with Patient A's surgery and no violation of Section 12-36-117(1)(cc) has been established with respect to Respondent's charting in Patient A's case.

The ALJ notes, however, that if it were to be determined, contrary to the findings of the ALJ, that an inadvertent tear of Patient A's bowel did occur during the surgery, such an occurrence would have constituted a surgical complication, documentation of which would be an essential chart entry. Further, the failure to document this event would have rendered Respondent's charting inaccurate. Under these circumstances, Respondent's failure to document the tear in his handwritten operative note, his dictated operative note, and his discharge/transfer note would constitute

repeated incorrect entries and repeated failures to make essential entries on patient records. Additionally, Respondent's entry in his handwritten operative note that no complications had occurred would constitute a false and incorrect chart entry. Consequently, if it were to be determined that Respondent inadvertently tore the patient's bowel during surgery, Respondent's charting of this event would constitute unprofessional conduct as defined in Section 12-36-117(1)(cc), C.R.S., because it would constitute repeatedly making incorrectessential entries and repeatedly failing to make essential entries in Patient A's records.

Patient B

With respect to Patient 8, the Formal Complaint charges that in connection with a March 1, 2005 ambulatory laparoscopic tubal ligation Respondent performed on the patient at PSC, Respondent failed to meet generally accepted standards of medical practice and therefore engaged in unprofessional conduct as defined in Section 12-36-117(1)(p) by failing to prescribe adequate analgesia for Patient B upon discharge from PSC; failing to respond to Patient B and/or her husband's calls regarding postoperative complications on March 1, 2005; and failing to ensure on-call coverage for his patients on March 1, 2005.[12] The Formal

12. The Panel makes no allegation of unprofessional conduct with respect to Respondent's performance of the surgery itself, including the number of attempts made to enter the abdomen and the fact of the bowel perforations, or with respect to Respondent's subsequent care of the patient at STMH.

Complaint also asserts Respondent's charting with respect to this patient violated Section 12-36-117(1)(cc).

Analgesia. The Formal Complaint asserts Respondent engaged in substandard medical practice by failing to prescribe adequate analgesia for Patient B upon discharge from the PSC on March 1, 2005. As established by the evidence, on March 1, 2005, Respondent performed a closed laparoscopic tubal ligation using electrocautery on Patient B at PSC, an ambulatory surgery center. Pursuant to Respondent's order, upon discharge from PSC, Respondent did not prescribe or provide any narcotic pain medication to Patient B and instead Patient B was instructed to take Advil, Tylenol, or Aleve for post-operative pain.

Respondent testified at hearing that his discharge orders for Patient B were consistent with his standing orders all for his post-operative laparascopic tubal ligation patients. Respondent justified this practice by asserting narcotics can mask pain, a potential indication of a complication. He believes that by instructing his patients to call if their pain is not controlled with non-narcotic pain relievers, he will be notified promptly of potential post-operative complications. The evidence established, however, that Respondent is effectively alone among OB-GYNs in his practice of failing to prescribe oral narcotic analgesics following laparoscopic tubal ligations. This is because non-narcotic pain relievers are simply insufficient to control post-operative pain from this procedure.

Appendix C

There was a dispute in the evidence as to whether Respondent's practice of not prescribing oral narcotics to his post-operative laparascopic tubal ligation patients constitutes substandard practice. While Respondent's expert asserted no standard of care exists with respect to this issue, the ALJ is persuaded by the Panel's expert who opined that the applicable standard of care in 2005, consistent with the actual (and objectively reasonable) practice of virtually all OB-GYNs, required an OB-GYN to prescribe a reasonable amount of oral narcotic pain medication for control of surgical pain following a laparoscopic tubal ligation. Respondent's failure to do so, even if Respondent's purpose was to assure that indications of a surgical complication were not masked by narcotic medication, constituted a failure to prescribe adequate analgesia to Respondent's laparoscopic tubal ligation patients in general and to Patient B in particular. Respondent's conduct and practice therefore failed to meet generally accepted standards of medical practice for OB-GYNs in 2005, and constituted unprofessional conduct, as defined in Section 12-36-117(1)(p). *See McCroskey*, 880 P.2d at 1194-1195 (the generally accepted standard of medical practice requires a physician to exercise the same degree of knowledge, skill, and care as exercised by other physicians in the same field of medicine during the time period in question; 'generally accepted standards' refers to norms of conduct applicable to similar persons in like circumstances and refers to an objectively reasonable standard of care).

Appendix C

Responding to Calls. The Formal Complaint alleges Respondent failed to "respond to Patient B and/or her husband's calls" regarding post-operative complications on March 1, 2005. The evidence established Respondent's staff was available on the afternoon of March 1, 2005 and did respond to calls regarding post-operative complications on that day, although Respondent himself was unavailable to see Patient B. The evidence did not establish the existence of a definitive standard of care, separate from the issue of ensuring on-call coverage, as discussed below, with respect to when a physician (as opposed to his staff) must respond to calls regarding post-operative complications. The ALJ therefore determines no independent violation of practice standards has been established with respect to this allegation.

On-Call Coverage. The Panel asserts in the Formal Complaint that Respondent also engaged in substandard care with respect to Patient B by failing to ensure on-call coverage for his patients on March 1, 2005. The evidence established Respondent was unavailable to his patients, and in particular to Patient B, on the afternoon of March 1, 2005; that he failed to ensure on-call coverage for his patients during that time, and that Dr. Staples was in fact unavailable to Patient B prior to 5 p.m. on that day. The convincing expert testimony established that it was insufficient for Respondent to assume, without actually checking, that Dr. Staples would be available to take call for Respondent during non-call hours. It was also insufficient for Respondent to rely on an emergency room for back up

during this period of time. Thus, Respondent's actions in March 1, 2005, in being unavailable to his patients and not assuring on-call coverage by another physician, and, in particular, Respondent's unavailability to Patient B without having assured Dr. Staples was available for coverage from 3:30 p.m. until 5:00 p.m. (when Dr. Staples' formal on-call responsibilities began), failed to meet generally accepted standards of medical practice at that time. Respondent's conduct in this regard therefore constituted unprofessional conduct, as defined in Section 12-36-117(1)(p).

Charting Issues. The Formal Complaint charges that by failing to record the number of attempts he made to enter Patient B's abdomen in the course of the laparoscopic tubal, ligation procedure, Respondent failed to make essential entries in the patient's record in violation of Section 12-36-117(1)(cc). The evidence indicated that commonly OB-GYNs do not document the number of such attempts. Additionally, the expert testimony did not establish such information would constitute an essential chart entry or that charting the number of attempts is required by generally accepted standards of medical practice. Moreover, the fact that Respondent initially did not chart the number of attempts but later chose to include this information in Patient B's hospital chart at SVMH, does alter these determinations. Therefore, the evidence failed to establish any violation of Section 12-36-117(1)(cc) with respect to this issue.

Appendix C

Finally, the Formal Complaint alleges with respect to Patient B that to the extent Respondent's explanations of his thought processes, discussions, medical reasoning and/or medical practice are inconsistent with his documentation in the patient's records, such documentation violated Section 12-36-117(1)(cc), C.R.S. At hearing, the Panel did not pursue this allegation or provide any evidence in support of this claim. The ALJ concludes this claim has not been established.

Initial Decision

Pursuant to the MPA, upon a finding, as is the case here, that a licensee has engaged in unprofessional conduct, the appropriate hearings panel must determine a proper sanction to be imposed. Available sanctions include a letter of admonition, probation, suspension for a definite or indefinite period, or revocation of a license to practice medicine. Section 12-36-118(5)(g)(III). in this case, the Panel seeks revocation of Respondent's license. Respondent asserts that no sanction or a minimal sanction is appropriate.

The Panel has established one instance of substandard care with respect to Patient A (electively and intentionally severing and removing a portion of the patient's bowel during the course of a hysterectomy in order to facilitate dissection of a fibroid) and two instances of substandard care with respect to Patient B (failure to prescribe adequate analgesia upon Patient B's discharge from an ambulatory surgery center

following a laparoscopic tubal ligation, and failure to ensure on-call coverage for his patients on the day of that surgery). Charting violations alleged by the Panel with respect to these patients have not been established. in addition to these violations, the Panel has established that Respondent was issued a Letter of Admonition in 2003 involving substandard care in connection with an obstetrical patient and discrepancies between the facts contained in the medical records pertaining to the patient in question and the facts reported in Respondent's response to the Panel concerning his care of that patient.

Respondent's proved statutory violations thus reflect failure to meet applicable standards relating to three specific areas: a surgical procedure, post-operative pain management, and assuring on-call coverage. Additionally, the record establishes a prior Letter of Admonition relating to an obstetrical patient and Respondent's failure to be forthright with the Board.

In determining an appropriate sanction in this matter, the ALJ must give first consideration to protecting the public. Section 12-36-118(5)(g)(III). In doing so, the ALJ must consider the severity of the offenses and other aggravating and mitigating factors.

The Panel asserts the only appropriate sanction in this matter that will support the public protection purposes of the MPA is revocation. In support of this position, the Panel points to the diverse nature of the substandard care issues in this case. Additionally, the

Panel focuses on Respondent's failure to recognize any deficiencies in his practice, his failure to modify his practice in any way in response to this proceeding, and his failure to take any steps to engage in a critical self-evaluation. The Panel also points to issues concerning Appellant's credibility and accuracy, as evidenced by the circumstances of his Letter of Admonition and what the Panel characterized as Appellant's attempts to "rewrite history" in connection with this proceeding. In light of these factors and the inherent difficulties of monitoring the solo practice of an OB-GYN in a town in which there are only two OB-GYNs, the Panel asserts no sanction other than revocations is appropriate.

Respondent, in contrast, relied at hearing on his assertions that no statutory violations occurred. Respondent asserted that no sanction should be imposed or, at most, limited educational requirements or practice requirements should be imposed if any violations were ultimately found to exist. Respondent also asserted that license revocation would be unjust on the basis of these two cases.

The ALJ concludes on the basis of the record that Respondent's unprofessional conduct, as established by the evidence, combined with his subsequent failure to take remedial measures or acknowledge his errors, warrants substantial discipline in order to protect the public health, safety and welfare. The ALJ is not convinced, however, that the scope and nature of the violations themselves establish that license revocation is required to protect the public. There is insufficient

evidence to establish these two cases are indicative of pervasive practice problems that would require license revocation or that the nature of the incidents themselves requires revocation to protect the public. Nevertheless, the evidence did establish, based on the nature of the substandard care in question, that significant practice restrictions and remedial measures are required to assure the public is protected.

This assessment was, in fact, echoed by counsel for the Panel, who indicated in closing argument that a license restriction short of revocation might have been appropriate in this matter if Respondent had exhibited appropriate contrition and critical self-evaluation.

However, Respondent's failure to articulate these sentiments at hearing may be more reflective of a litigation strategy than any actual failure on Respondent's part to recognize his deficiencies.

The ALJ believes the Panel's public safety and related concerns can be appropriately addressed by placing Respondent's license on probation, requiring a thorough assessment of Respondent's knowledge and clinical abilities, imposing appropriate educational requirements, and requiring practice monitoring.[13] The

13. While such requirements, including the requirement for practice monitoring, may prove onerous to Respondent, particularly in his current practice setting, they will serve necessary public protection purposes. Whether Respondent wishes to accept these appropriate conditions or relinquish his ability to practice in this state should bee decision left to Respondent, rather than one preempted by the Panel through revocation.

ALJ thus determines that an appropriate sanction in this matter is a five-year period of probation. Conditions of that probation shall include, if deemed appropriate by the Hearings Panel, requirements that Respondent undergo an assessment of his practice by the Colorado Physician Evaluation Program, comply with the recommendations of that assessment; participate in other education as required by the Hearings Panel, and undergo practice monitoring as determined by the Hearings Panel.

It is therefore the Initial Decision of the ALJ as follows:

1. Respondent's license to practice medicine shall be placed on probation for a period of five years, subject to terms and conditions of probation as described below and *such* further or substitute terms and conditions as established by the Hearings Panel in its Final Agency Decision.

2. If deemed appropriate by the Hearings Panel, as a condition of probation Respondent shall complete, by a date to be determined by the Hearings Panel in its Final Agency Decision, a practice assessment with Center for Personalized Education for Physicians (CPEP) to determine the scope of any deficiencies in his medical practice. If, following that assessment, CPEP recommends that Respondent should be required to complete an education plan or other remedial education or training program, the Hearings Panel shall review such recommendation. If after completing such review

the Hearings Panel agrees such program is warranted, Respondent shall be required to successfully complete the recommended education and/or training program as a further condition of his probation.

3. The Hearings Panel may impose education or training requirements as a condition of Respondent's probation instead of or in addition to those recommended by CPEP.

4. Respondent's practice shall be subject to monitoring during the period of probation in accordance with requirements established by the Hearings Panel in its Final Agency Decision

5. Respondent shalt be responsible to bear all costs associated with his CPEP evaluation, as well as the costs associated with complying with any CPEP recommendations or requirements or other education requirements, and the costs of practice monitoring.

DONE AND SIGNED
January 18, 2008

s/ Judith F. Schulman
JUDITH F. SCHULMAN
Adminstrative Law Judge

APPENDIX D — ORDER OF THE COLORADO SUPREME COURT DENYING PETITION FOR WRIT OF CERTIORARI DATED SEPTEMBER 14, 2009

Colorado Supreme Court
2 East 14th Ave., Fourth Floor
Denver, CO 80203

Supreme Court Case No:
2009SC444

Certiorari to the Court of Appeals, 08CA1254
Board of Medical Examiners, me20070003

Petitioner:

Gary McKinney,

v.

Respondent:

Colorado Board of Medical Examiners.

ORDER OF COURT

Upon consideration of the Petition for Writ of Certiorari to the Colorado Court of Appeals and after review of the record, briefs, and the judgment of said Court of Appeals,

IT IS ORDERED that said Petition for Writ of Certiorari shall be, and the same hereby is, DENIED.

BY THE COURT, EN BANC, SEPTEMBER 14, 2009.